| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 005002 | A. BUILDING: _____ B. WING _____ | 04/15/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| METHODIST HOSPITALS INC | 600 GRANT ST GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>This visit was for investigation of a State hospital complaint.<br><br>Complaint Number:<br>IN00141098<br>Unsubstantiated: lack of sufficient evidence<br><br>Date: 04/15/14<br><br>Facility Number: 005002<br><br>Surveyor: ReBecca Lair, LCSW<br>Medical Surveyor<br><br>Methodist Hospitals is in compliance with 410 IAC 15-1.5-8, Physical plant, maintenance, and environmental services, Hospital Licensure Rules.<br><br>QA: claughlin 04/29/14 | S 000 | | |